

KEY PERFORMANCE INDICATORS FOR HEALTH NAVIGATOR PROGRAMS

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INTRODUCTION:

Standardization of the roles, training and competencies of unlicensed health navigators is critical to the success of health navigation or navigators as an intervention to improve health equity. The standardization of the lay navigator role, training and competencies facilitates the identification of key indicators for the systematic collection of data about the activities, characteristics, and outcomes of health navigator programs. The key indicators can be used to make judgments about the health navigator program, improve program effectiveness, and/or inform decisions about future programming. In other words, standardization underlies the evaluation of health navigator programs in healthcare agencies, including the evaluation of their impact on patients' engagement in their care and their confidence in their ability to actively participate in the prevention or early diagnosis and management of their chronic diseases. One way to look at this standardization is to think of it as promoting fidelity to the intervention model.

Based on evidence from the research literature on health navigators, national and local meetings and the products and outcomes such as health navigator evaluation tool kits and training on supervising health navigators and evaluation of lay navigator programs produced by CDPHE-funded grants, CDPHE developed a list of key indicators for measuring the outcomes of CDPHE-funded health navigator grants or health navigator programs. The key performance indicators are divided by evaluation related to planning (formative evaluation), implementation (process monitoring and evaluation) and outcomes (outcome monitoring and evaluation as well as impact evaluation).

The key indicators are not written for any particular type of health navigator program, service setting, disease entity or health behaviors. The indicators selected should be based on the objectives of the health navigator program and the available funding for the evaluation process.

These key indicators are designed to be used in conjunction with the following CDPHE documents produced as part of the Health Navigator Workforce Initiative:

- *Differentiating between Community Health Workers and Health Navigators*
- *Health Navigator Entry-Level Competency Statements*
- *Barriers to Care List*

DEFINITIONS:

Lost to follow-up: At least 3 attempts to locate the person have been made including 2 phone calls and a written letter. A certified letter is preferred in the cases where an abnormal finding has been identified and the person needs further diagnostic test and/or education.

*Health navigator includes patient navigator, resource navigator, lay-navigator, non-licensed navigator, etc., but not licensed providers or lay community health workers.

Outreach:	When a health navigator goes out into the community, clinic waiting areas, health fairs, etc. to educate people about services and goals of the program (e.g. early detection of chronic disease) or perform health screenings.
Reach:	Health navigator “reach” individuals when they actually deliver navigation such as schedule an appointment or assist with barriers.
Scope Creep:	Occurs when health navigator is doing “other duties as assigned” more than 5% of the time because other staff do not understand the evidenced-based role of the health navigator, and thus there is not fidelity to the health navigator role that produces the evidenced-based outcomes documented in the literature.

PROCESS INDICATORS FOR THE START-UP OF A HEALTH NAVIGATOR PROGRAM WITHIN AN AGENCY:

Gap(s) in whole-person health and access to care have been identified and the health navigator is the appropriate intervention for this gap (i.e., lay, non-clinical navigator can actually impact the gap).

Community partners, supporters and resources identified to support health navigator role in addressing whole person and population health.

External and internal communication plan about the program completed, and time-line for program’s roll-out specified.

Competency-based health navigator training completed (See *Health Navigator Entry-Level Competency Statements*).

Health navigator supervisor training completed. Examples of content include:

- Evidenced-based roles and functions of lay navigator
- Patient and system key indicators
- Job description and hiring of qualified health navigators (i.e., qualities and characteristics to look for)
- Coaching skills for motivational interviewing
- Health navigator role clarity/responsibility on day-to-day basis
- Integration of health navigator on healthcare team
- QI and metrics for success

Work space provided for health navigator which decreases potential of “scope creep” (e.g., the bull pen is NOT recommended).

Target population identified with registries/EMR in place.

Evidenced-based clinical guidelines in place (e.g., US Preventative Task Force, Clinical Guideline Standards and Quality of Care, Guide to Community Preventative Services).

Individual health navigator goals and expectations/performance management identified, including clarity on data collection and documentation for reporting purposes.

How to assign population/patients to health navigators determined (e.g., number of chronic conditions, co-morbidity, ER use, not-up-to-date on screenings, health disparities, etc).

Caseload, panel size or ratio health navigator FTE/patients estimated. To calculate consider:

- Number of patients in active navigation
- Number of encounters between health navigator and patient (time)
- Length of time of these encounters (time)
- Number of days a patient has been navigated (time)
- Number of barriers population faces (e.g., complexity of target population such as homeless, refugee, persons with disabilities, dual diagnosis, LGBTQ, oral health concerns)

Standard processes and procedures in place, including tracking and evaluation tools, standard work flow diagrams and how (e.g., by language spoken, from similar community as health navigator, complexity of the navigator's case load mix) and by whom (e.g., providers, manager of navigator, team leader) health navigators are assigned to patients.

Orientation and mentoring plan specific to role of health navigators and populations served identified.

Interdisciplinary team educated about role of health navigators and participation in defining and integrating the navigator role on the team.

How and where (e.g., electronic medical records, electronic programs designed in-house or purchased, paper records, team meetings, etc.) health navigator can share information with healthcare team and obtain needed information is decided. Note: Because health navigators are non-clinical members of the team, this decision may be complex.

HEALTH NAVIGATOR PROGRAM PROCESS MONITORING INDICATORS:

(i.e., data describing the characteristics of the population served, the services provided and resources used to deliver those services. Answers such questions as: What services were delivered? What population was served? What resources were used?)

Outreach-demographic information such as location, number of persons, services/information provided.

Reach-demographic information of the population served. For example:

- Number of patients in active navigation
- Age or date of birth
- Race/ethnicity and/or gender, disability (e.g., physical, cognitive emotional), refugee
- Payer type
- Zip code
- Primary language spoken at home
- Disease type/target population
- Routine or diagnostic screening type

HN PROGRAM PROCESS EVALUATION INDICATORS:

(i.e., collects more detailed data about how the intervention was delivered, differences between the intended population and the population actually served, and access to the intervention. Answers such questions as: Was the intervention implemented as intended? Did the intervention reach the intended audience? What barriers to whole person health did patients experience?)

Barriers to whole person health identified with patient (*See Barriers to Care List*).

Date patient connected with health or medical home (visit scheduled) with date that patient completed first visit:

- Type of provider (e.g., mental health, primary care, oncology, oral, etc.)
- Type of contact (e.g., phone, text, home visit, face-to-face in office/clinic/community/shelter)
- Duration of time spent with patient
- Number of referrals given/made and number of successful referrals (i.e., completed by patient) with health navigator follow-up
- Type of referral (e.g., primary care, specialty care, social services, behavioral health, community resources, oral health, etc.)
- Type of service provided at referral (e.g., screening, diagnostics, between-visit care; community service such as legal, food, financial assistance, housing, etc.)

Average number of contacts to get person to a referral, screening, diagnostics, community resource, etc.

Number and type of intervention program sessions attended (e.g., support groups, diabetes classes, dance therapy, art therapy, nutritional cooking, etc.).

Number of emergency room visits (may need data on whether visit was something that could have been prevented, not just that person used emergency room. This can be determined by diagnostic code assigned in emergency room).

Number of hospitalizations (may need data on whether it was related to acute episode or could have been prevented. This can be determined by diagnostic code).

Number of patients who complete referrals.

Number of “no shows” per patient.

Number of patients “lost to follow-up.”

Patient engagement survey results.

Patient experience survey results.

OUTCOME MONITORING INDICATORS:

(e.g., collects data about patient outcomes before and after intervention, such as knowledge, attitudes, skills, behaviors. Answers the question: Did the expected outcomes occur as a result of the health navigator intervention?)

Number of patients with healthcare coverage.

Number of patients with health or medical home and initial primary care visit completed.

Number of patients who are up-to-date on health screenings based on clinical guidelines.

Number of patients who report positive change in health literacy, understanding health information, treatment and screening recommendations, prepared for healthcare visit (e.g., bowel prep for colonoscopy or fasting, medication adherence, etc.).

Health indicators at beginning of health navigator intervention and while receiving navigator services (e.g., BMI, smoking status, A1C, weight, etc).

Number of patients who had recommended diagnostic follow-up within time period (such as 30, 60, or 90 days) or were referred to intervention program.

Number of sessions of evidenced-based preventative health programs attended (e.g., prediabetes, diabetes, high cholesterol, hypertension, kidney disease, obesity, therapy groups, behavioral health, oral health, etc.).

Number of patients that did not receive recommended diagnostic follow-up within XX days or did not participate in the recommended intervention program.

Number of patients that did not receive recommended diagnostic follow-up within XX days or did not participate in the recommended intervention program.

Number of patients who initiated treatment within XX days.

Number of patients that did not initiate treatment within XX days.

Number of patients who fully understand their screening and/or treatment or intervention program recommendations.

Number of patients adhering to screening and/or treatment or intervention recommendations (includes medication adherence).

Number of patients who report positive change in health behavior (e.g. engagement in their care, smoking less, increased walking, increased number of vegetables and fruits eaten daily, etc.).

Patient no-show rates for appointments that are the focus of the health navigator program (e.g., for cancer treatment, health navigators could focus on the following appointments: oncology, chemo and radiation therapy, primary care, behavioral health, oral health and ER visits for chronic disease and cancer treatment side-effects).

Patient lost-to-follow-up rates for appointments and/or intervention programs.

Patient engagement survey results.

Patient experience or satisfaction survey results.

Cancer specific:

- Number of patients who received a survivorship care plan.

OUTCOME EVALUATION INDICATORS:

[e.g., collects data before and after the intervention (e.g., health navigators integrated into care team) for patients as well as with a similar group that did not participate in the intervention being evaluated. Answers the question: Did the intervention cause the expected outcome?]

Same as above, but compare with patients who did not receive health navigator services (this could be baseline data prior to implementation of the program).

IMPACT EVALUATION INDICATORS:

(e.g., collects data about specific diseases at jurisdictional (county, agency service area, state) regional, and national levels. Answers the question: What long-term effects do interventions have on x-disease/health status?)

Data showing trends in specific disease rates (cancer by type, cardiovascular disease, obesity, etc.).

Data showing trends in mortality rates for cancer, cardiovascular, obesity mortality rates, substance abuse.

Data showing trends in health disparities or health equity.

Data showing trends in healthcare coverage rates.

Data showing trends in persons who can identify their **health home** and oral health provider.

Trends in emergency room use.

Trends in hospitalization, re-admissions.

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